Medicaid Adjustment Request Form (ADJ-02)

Mail to: Adjustments
P.O. Box 241684
Montgomery, AL 36121-1684

Section I: Provider Pay-To Information
NPI Number

Provider Name
Address

Overpayment: Please process to correct the overpayment
Underpayment: Please process to correct the underpayment
Information correction: Please process to reflect the correct information

Section II: Paid Claims Information
Please enter the following data from your remittance advice:

ICN Number:
Recipient ID Number:
Date(s) of Service:
Billed Amount:
Recipient Name:
EOP Date:
Paid Amount:

Section III: Description of the Problem

Signature: __________________________ Date: __________________________

Gainwell Use Only
Date of Adjustment: __________________________
Reviewer: __________________________

Adjustment action:
Pay
Recoup

Revised 12-07-20